Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CESAR DUCLAIR, MD
3100 TIMMONS LANE #250
HOUSTON, TX 77027

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-2417-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. The requestor was asked to determine if there is an injury that resulted from the claimed incident. (See requestor's DWC-60 packet) The EES-14 form identifies this request fall under "Other (Similar Issues). (See requestor's DWC-60 packet.) 2. The requestor answered this then billed code 99456-W7. 3. Rule 134.204 at (i)(1)(F) states that issues similar to those described in subparagraphs (A) – (E) are to be shall be billed and reimbursed in accordance with subsection (k) with the use of the additional modifier "W9." 4. Texas Mutual declined to issue payment for code 99456-W7 for that reason. 5. The request for reconsideration does not address the coding. Hence Texas Mutual maintained its denial. For these reasons no payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 04, 2010	99456-RE-W7	$500.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 12, 2011
   - CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION AT LEAST ONE REMARK CODE MUST BE PROVDIED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
   - CAC-4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. CPT AND/OR MODIFIER BILLED INCORRECTLY. SERVICES ARE NOT REIMBURSABLE AS BILLED.

   Explanation of benefits dated March 7, 2011
   - CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION AT LEAST ONE REMARK CODE MUS BE PROVDIED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
   - CAC-193 – ORIGINAL PAYMENT DECISION BEING MAINTAINED UPON REVIEW. IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - CAC-4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824.
   - 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. CPT AND/OR MODIFIER BILLED INCORRECTLY. SERVICES ARE NOT REIMBURSABLE AS BILLED.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor (DD) billed $500.00 for CPT Code 99456-RE-W7 for a Division requested determination of whether the injury resulted from the claimed incident. Review of documentation supports that the Division ordered an examination on the EES-14 form in the similar issues section. The specific wording of the service requested is "to determine if there is an injury resulting from the claimed incident." This is a service that a provider would bill with both the –RE and -W9 modifiers. The requestor billed with the incorrect –W7 modifier for the service. That modifier is only to determine if the employee's "disability is a direct result of the work related injury" and is not the same service as what was requested and also performed.
2. The requestor is not entitled to reimbursement for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		January 06, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.